HEALTHY FAMILIES MENTAL HEALTH RESPONSE FORM

Section 1:

Enrollee's Name: _____ DOB: _____

SSN/Healthy Families Plan Membership #: _____ County Identifier #: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____

Section 2:

Enrollee's Healthy Families Health Plan: _____ Date: _____

Referring Party: _____ Phone: _____ FAX: _____

Address: _____

❒ Designated Health Plan (HP) Representative (e.g., Care Coordinator, Case Manager, etc.)

❒ HP Primary Care Provider ❒ HP Mental Health Provider ❒ HP Alcohol & Other Drug (AOD) Service Provider

Section 3:

ENROLLEE ELIGIBILITY

❒ The enrollee meets the criteria for services for children with Severe Emotional Disturbance (W&I Code 5600.3)

❒ The enrollee does not meet the criteria for children with Severe Emotional Disturbance (W&I Code 5600.3)

Axis I Diagnosis (REQUIRED): _____

_____

Section 4:

CRITERIA ESTABLISHING ENROLLEE'S ELIGIBILITY FOR SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE (SED)

The enrollee met the criteria in one or more of the following three categories (circle A, B and/or C):

A. As a result of a mental disorder the enrollee has substantial impairment in at least two of the following areas:
- ❒ Self-care
- ❒ School functioning
- ❒ Family relationships
- ❒ Ability to function in the community

And one of the following conditions occur:
- ❒ The enrollee is at risk for removal from his/her home
- ❒ The enrollee has been removed from his/her home
- ❒ The mental disorder/impairments have been present for six months, or are likely to continue for more than one year without treatment

B. The enrollee displays: psychotic features, risk of suicide, risk of violence due to mental disorder.

C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Section 5:

DISPOSITION
(letters A – D must be completed)

A. Refer back to Health Plan for basic Mental Health Services Yes No

B. Refer back to Health Plan for basic Alcohol and Other Drug Services Yes No

C. County Mental Health Department to provide SED services Yes No

D. Refer to another service Yes No

If "Yes" list services (s):_____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

Section 6:

Evaluating Clinician Name (printed): _____ Phone: _____

Agency Name: _____

Address: _____

Signature: _____ Date: _____

After assessing the client's treatment needs, a Department provider must follow the appropriate course of action listed below.

All Department providers must refer clients from all other health plans who need Basic Services back to their health plan which will connect the client to a health plan network provider.

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